13. Have you received the following vaccinations?

Docment Vaccination Status	Date last vaccination received (or date of final vaccination in series)
For all responders	
Tetanus	
Hepatitis B	
Influenza	
Pandemic Influenza	
For selected responders	
Pneumococcal Vaccine	
Hepatitis A	
Measles/Mumps/Rubella	
Polio	
Varicella	
Rabies	
Anthrax	
Smallpox	

Enhanced Pre-deployment Evaluation (to be completed by the Emergency Responder) [created by the ERHMS Workgroup]

Date: _____

Name: _____

Date of Birth: _____

Job Title: _____

Employer: _____

Job Location: _____

Please answer each of the questions to the best of your knowledge:

1. Health Status (pre-deployment)
    a. Pre-existing medical and mental health conditions: _____

    _____

b. Past surgeries/dates: _____

_____

2. Any medical and/or fitness concerns that you would like to be addressed:

_____

_____

_____

3. Medications you presently take:

_____

_____

_____

_____

4. Allergies (food, medicine, environmental):

_____

_____

_____

_____

5. Substances:

e. Alcohol Use (Amount per day): _____

f. Smoking (number of cigarettes per day): _____

g. Other drugs or substances (amount per day): _____

6. Fitness Level:

a. Height: _____ inches

b. Weight: _____ pounds

c. BMI (to be determined by health care provider): _____

d. Conditions that may impair your activities of daily living: _____

_____

e. Conditions that may limit your ability to perform strenuous activity:_____

_____

f. Score on most recent physical fitness test (if applicable):

Score of _____ out of a possible _____

7. Job-specific Risk Factors:

a. Do your emergency response activities potentially require you to wear respiratory protection? Yes / No / Don't know

b. Have you been fit-tested for an N95 respirator or other respirator protection? Yes / No / Don't know

c. Do your emergency response responsibilities involve the potential of exposure to hazardous substances? If yes, please describe: _____

_____

8. Vision corrected_____ and uncorrected_____

9. How is your hearing? Excellent / Good / Fair / Poor

10. Do you have a history of any of the following?

a. Chest pain Yes / No

b. Syncope Yes / No

c. Abdominal pain Yes / No

d. Seizure disorder Yes / No

e. Heat exhaustion/heat stroke Yes / No

f. Other medical / dental / or psychological conditions Yes / No

If yes, please describe: _____

_____

_____

11. Have you received the following vaccinations?

Document Vaccination Status	Date last vaccination received (or date of final vaccination in series)
For all responders	
Tetanus	
Hepatitis B	
Influenza	
Pandemic Influenza	
For selected responders	
Pneumococcal Vaccine	
Hepatitis A	
Measles/Mumps/Rubella	
Polio	
Varicella	
Rabies	
Anthrax	
Smallpox	

12. Do you have any limitations or concerns about deploying to austere conditions (such as temperature stress, no or intermittent electricity, and few services/supplies)?

_____

_____

13. Describe any functional and/or access needs that you may have due to some form of disability.

_____

_____

To be completed by Agency / Organization / or Employer:

14. Exposure Anticipation:

a. Anticipated deployment location (as specific as possible): _____

_____

b. Anticipated tasks to be performed (as specific as possible): _____

_____

c. Anticipated circumstances under which tasks will be performed (i.e., list of disaster types): _____

_____

d. Characteristics of expected work locations and relationship to known or suspected CBRN (chemical, biological, radiological, and nuclear) agents or conditions: _____

_____

15. Anticipated date of deployment:

16. Anticipated duration of deployment:

17. Control anticipation:

g. Anticipated need for PPE? Yes / No

h. Anticipated type of PPE needed: _____

_____

i. Adequate pre-incident training for tasks? Yes / No

j. Anticipated shift schedules: _____

_____